



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

518-804-4000 telephone • 512-804-4811 fax • [www.tdi.texas.gov](http://www.tdi.texas.gov)

## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

JAMES BALES, MD  
P.O. BOX 741865  
DALLAS, TX 75374

#### **Respondent Name**

NEW HAMPSHIRE INSURANCE CO

#### **Carrier's Austin Representative Box**

Box Number 19

#### **MFDR Tracking Number**

M4-12-0813-01

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "AN ORIGINAL BILL AND A RECONSIDERATION WERE SUBMITTED, THE CURRENT RULES ALLOW REIMBURSEMENT."

**Amount in Dispute:** \$650.00

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** A copy of dispute was placed in carrier rep box on November 10, 2011 with no response to MFDR

**Response Submitted by:** NA

### **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 16, 2011	99456-WP-W5	\$650.00	\$ 650.00

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

#### **Background**

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services effective March 1, 2008.
- The services in dispute were reduced/denied by the respondent with the following reason codes:  
No Explanation of Benefits provided by either party.

### Issues

1. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to reimbursement?

### Findings

1. The requestor billed the amount of \$650.00 for CPT code 99456-WP-W5 for DD examination for Maximum Medical Improvement/Impairment Rating (MMI/IR). Review of the documentation supports that the doctor assigned MMI and performed an IR examination for one body area. Per 28 Texas Administrative Code §134.204(j)(3)(C), the Maximum Allowable Reimbursement (MAR) for MMI is \$350.00. Documentation supports the musculoskeletal rating of the ankle (lower extremities) per the Range of Motion (ROM) IR method per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(II)(a) with a MAR of \$300.00. The combined MMI/IR MAR is \$650.00.
2. The respondent has not paid any amount of reimbursement for CPT code 99456-WP-W5, therefore \$650.00 is recommended.

### Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is \$650.00.

### **ORDER**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$650.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

### Authorized Signature

_____	_____	January 12, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

### **YOUR RIGHT TO REQUEST AN APPEAL**

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**